

Community Health - Professional Practice Committee Work Situation Report

Section 1: General Information

Name(s) of Employee(s): _____
Employer: _____
Main Office/Team/Area/Program: _____
Date of Occurrence: _____ Time: _____
Hours Worked: _____ On Call Hours: _____
Regular Staff: RN _____ Clerical Support: _____
Actual Regular Staff: RN _____ Clerical Support: _____
Staff Shortage Due to: Sick Call Vacancies Emergency Leave Vacation
RN Staff Overtime: Yes No How Many Staff _____ Total Hours _____
Did this cause you to miss your: Meal Period: Yes No Rest Period/Break: Yes No
Name of supervisor reported to: _____

Section 2: Details of Occurrence

Provide a concise summary of the occurrence and how it impacted client care:

Was the safety of the client or the nurses compromised? Yes No How? _____

Workload not completed: _____

Is this an isolated incident? Yes No Ongoing problem? Yes No

Section 3: Client Care and Other Ongoing Factors to the Occurrence

- Change in Client Acuity: Provide details _____
- # Family Members _____
- Clients Assigned at Time of Occurrence _____
- Non-Nursing Duties: Specify _____
- Standards Not Met _____
- # Of New Clients to be Assessed (Ongoing Referrals) _____
- Safety in Jeopardy: Please Specify _____
- Lack of/Malfunctioning Equip: Details _____
- Weather/Conditions _____
- Travel/Distance _____
- Presentation Cancelled _____
- # Of Transfers from Service: _____
- Unanticipated Assignment/Uncontrolled Variables: Specify _____
- # Of Discharges from Program _____
- Other - Specify: _____

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Section 4: Workload

At the time of the occurrence, the planned workload was:	Planned (P)	Actual (A)	Time Planned	Actual Time
Home visits/School visits/Clinics/Telephone Calls/Hospital/etc				
Public Meetings/Team Meetings/Office Work etc				
Documentation/Administration (i.e. Phone, paperwork, supplies)				
In-service Education/Presentations				
Travel (number of trips)				
Number of Clients Assessed				
Other (i.e. giving a presentation, etc)				
If staff made available, please identify the number of staff provided, their category:				
Category (PHN, Clerk, Other)	Amount of Time Staff Available	Orientation to Site Required: Yes/No State Orientation Time		

Section 5: Recommendations

Please check-off one or all of the areas below you believe should be addressed in order to prevent similar occurrence:

- In-service
- Caseload Review of client/family needs
- Orientation
- Part-time pool
- Professional standards
- Review: RN: Client Ratio
- # Support staffing
- Review policies and procedures
- Perform Workload Measurement audit

Equipment: Specify _____

Other: please specify: _____

Section 6: Employee Signature

I/We request these concerns be forwarded to the Professional Practice Committee

Signature: _____	Date: _____
Signature: _____	Date: _____
Signature: _____	Date: _____
Signature: _____	Date: _____
Date Submitted: _____	Time: _____

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Section 7: Management Comments

Please provide any information in response to this report, including any actions taken to remedy the situation where applicable

Management Signature: _____ Date: _____

Section 8: Recommendations of Professional Practice Committee

The Professional Practice Committee recommends the following to prevent similar occurrences:

Is this issue resolved? Yes No

Copies to: 1. Manager 2. NBNU Local President 3. Member

Dated: _____